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CO-OPERATIVE NURSING HOMES FOR MEDICAL PRACTITIONERS IN THE PRESIDENCY.

BY

CAPTAIN E. S. GOPALAN, M.B., M.S., A.I.R.O.

It is impossible at present for all medical practitioners to provide for competent nursing of their patients in individual nursing homes of their own. A few practitioners may have the necessary conditions to organize their own private nursing homes in a competent manner. The employment of full-time nurses in a middle-class family for treating a case of enteric fever running for weeks is financially difficult. Moreover the charges for such essential bacteriological investigations as Blood culture, Widal, etc., are so prohibitive in private and Governmental institutions, that a practitioner stands the risk of losing his client, if he suggests such costly investigations. Even biochemical investigations such as blood urea and blood sugar are so costly in private practice that a practitioner has sometimes to grope in the dark. If he is a sincere well-wisher of the patient, he has no option except to take steps to admit the patient in a public institution, which provides nursing and which, in this Presidency being mostly Governmental institutions, can get all the investigations done, with practically no cost to the patient. A middle class patient, and more so, a wealthy patient, left to himself, would like to be treated by his own doctor, perferably in his own house, or in an institution to which his doctor can have access. Such instances of doctors losing their cases, for want of competent nursing and laboratory facilities at moderate expense, are occurring every day. And the economic loss to the practitioners, computed collectively, will be very great indeed. In this fundamental shortcoming, the doctors attached to state institutions are at an advantage since they can admit patients into the hospitals.

One important step which will remove this defect is the starting of co-operative nursing homes by the practitioners themselves. My conception

of a co-operative nursing home is a very broad one. I should have it as the centre of all the conjoint medical activities of the practitioners of the locality. I shall explain this more fully in the subsequent paragraphs.

Competition from Government Institutions.

If the Government is serious that nursing homes started by medical practitioners should thrive, they should do away with two invidious distinctions they are making to-day, (1) as regards the establishment and other charges they levy on Government servant patients and non-Government patients and (2) the reservation of certain general wards for a certain community paying or non-paying.

When a Government servant in higher grade of pay is admitted into one of the special reserved rooms for a surgical disorder requiring a major operation, he pays only 30% of the establishment charges and no operation fees which in the case of non-officials ranges from Rs. 50 to Rs. 300. The non-official has to pay a minimum establishment charge of Rs. 10 per diem. I do not hold any brief for the non-official. I only want to point out that the Government by showing this extreme concession to its very well paid officers, stands in the way of the evolution of nursing homes by the independent medical profession. Does the Government exist to cater to the needs of its wealthy officers alone? Is not the non-official tax payer and the poor tax payer their concern also? If by levelling up the charges for the Government official and the non-official, on an equal par, you put more money into the hands of the independent medical profession, you can receive proportionate taxes from the medical men and the State is bound to gain eventually. Whereas by showing ultra-concession to the Government offices, the Government loses its ligitimate income and the private medical man is perpetually famished and unable to pay decent taxes. The Government loses both ways. I know from experience, what a lot it costs the Government to look after a few individuals in the officers' quarters, compared to a over-crowded general ward with 32 sanctioned beds and an equal number of so-called extra beds accommodated on irritating korai mats. As a matter of fact, the officers' quarters are over-staffed and the general wards under-staffed. Why not do away with this inequality and give the independent medical profession an opportunity to serve the needs of the non-officials and officials in competent private nursing homes? In my experience, a Government servant as such, does not go to a Government institution for ordinary treatment to himself and his family. He has usually a family doctor who is invariably a private medical practitioner. Because the charges in a Government institution are ridiculously low, he is attracted to that place for in-patient treatment. If the charges are uniform, in nine cases out

of ten he would seek treatment at a private nursing home and can have the benefit of his own family doctor and his consultants. So I should personally even go further and demand that anyone, official or non-official, getting a monthly income of Rs. 100 and over, should not be entitled to treatment, out-patient or in patient, in a Government hospital, ordinarily. But cases requiring special attention which can be had only at such institutions may be treated on charges which must be the same for the Government and non-Government patients.

Advantages of Co-operative Nursing Homes.

(1) *Advantages to the practitioner.*—A practitioner need have no fear of losing his cases, his fees and his reputation. I know, as a practitioner, the value of reputation of treating a protracted case successfully through thick and thin. Again taking a case of enteric fever, for example, majority of cases, in private practice, are sent to public hospitals invariably during the second week, when the patient's relations are dissatisfied with the progress of the case. If there is a co-operative nursing home the practitioner can continue to treat his case in that institution, with or without the aid of a medical consultant. Even the junior most practitioner can take up the responsibility.

(2) *Advantages to the public.*—Patients can be treated by their own family doctors and their consultants. In Government and public institutions such a thing is impossible. I have seen some practitioners who after having admitted some of their cases in Government institutions, find it extremely difficult to follow the cases in the hospital. This can never happen in a nursing home managed by the practitioners themselves.

Some patients have a real dislike of Hospitals. The practitioners and the relatives have to use a good deal of persuasion to make such a patient agree to get into a hospital. As medical men, we all know, what an important part psychology plays in the cure of the disease. In order that a patient may get a reasonably quick cure he must have absolute confidence in the institution and the doctors and nursing staff attending on him. A patient, admitted against his will into an institution, where the doctors are strangers and the nursing staff are overworked, had better not be admitted at all. It were better he was left alone. But in a nursing home, the transition from the home atmosphere is not violent, and the nursing staff free of administrative routine have more time to devote to their patients. The patient's psychological bias is respected and he has greater chances of quick restoration to normality, other circumstances depending on the nature of the disease, being favourable. Rightly, or wrongly, a patient especially

an Indian patient, wants to have contact with his relatives when he is sick. Though, even in nursing homes, unauthorized visitors must be excluded, the patient's wishes to see certain friends and relatives must be fully complied with. The relations' wishes should never influence us to worry the patient with too many visitors. In a public hospital, it is all red-tapism and there is no opportunity of studying each patient as regards his requirements in the matter of company with his friends and relations.

(3) *Standard and level of practice will rise.*—By giving patients the best nursing possible and by the continuous contact of the family doctor with the whole process of disease, the standard of practice is bound to rise and the general practitioner becomes a clinical research worker of no mean order. His experience is enriched and this is an asset when he encounters similar disease conditions subsequently.

(4) *Common meeting place of the practitioners.*—The nursing home automatically becomes the common meeting place of the practitioners and the same locality can be made the centre for clinical laboratory, radiological institute, medical library and reading room, pathological museum, co-operative dispensary and co-operative drug stores. It may also accommodate the office of the city, district or taluq medical associations.

Thus as I have mentioned before, the co-operative nursing home should not only be a nursing home in the proper sense, but a centre of the collective activity and achievements of the private medical practitioners.

(5) If profits accrue as they should, a certain portion may be allowed to accumulate and may be utilized to cater for patients of ordinary means who cannot pay the usual nursing home charges but can pay a percentage thereof. In any case the treatment should be undertaken by the patient's doctor and the doctor's consultants.

Shares.

I do not consider myself a specialist in the business aspect of the question. I should have no hesitation in seeking advice from gentlemen who have made special studies and who have experience of co-operative institutions. But, personally, I should have each share at Rs. 100, no person being allowed to have more than 10 shares. I should also take in as many non-medical shareholders as possible subject to the maximum limit of 10 shares each. But the administration should be run by the medical shareholders only. The administration among the medical share-holders should be entirely democratic, the man holding one share should have as

much voice in the administration as the man holding 10 shares. The non-medical share-holders should be entitled to concession in the establishment charges, in the visiting charges of their doctors and other charges also. In the establishment charges concession to the extent of 25 per cent can be given. In the visiting charges concession to the extent of 50 per cent can be given. In other charges concession from 25 per cent to 50 per cent can be given according to the nature of the services rendered. The non-medical share-holders must also be given preference, in priority of admissions of patients recommended by them, at the rate of one patient at a time for every share held by them. The concessions should be given not only to the shareholders but to their actual dependents. So far as medical shareholders are concerned, there should be no limit to the number of patients to be admitted by them but preference should be given to priority of applications. In cases of an urgent nature, the urgency of the disease should be the only consideration.

Loans.

I believe co-operative banks will help us with a loan to the extent of our share capital by what is known as "cash credit system". So, to begin with, even if our share capital is moderate, we can get a loan to push our scheme through.

How to Start.

For commencing work we need not have our own buildings but can engage a rented bungalow which can satisfy our requirements.

Scale of Charges.

I should have the scale of charges to vary from Rs. 3 to Rs. 10. Details can be worked out later according as the cases come under the following categories—serious medical, serious surgical; moderate medical, moderate surgical; minor medical, minor surgical—and according to the accommodation needed by the patient and the attention necessary for the patient. Other details can be thrashed out by the individual co operative societies starting the nursing homes.

Conclusion.

I may be a dreamer, but in the modern world, dreams of to-day, are often times accomplished facts of the next decade if not the next year. The sage Valmiki's sublime dream of aerial journeys are an every day affair in the present civilised world. But co-operation is no dream. It is an established fact and for us, medical practitioners, the path has been made and smoothened for our triumphal journey in our automobiles by the pioneers in co-operation.

EFFECT OF NATURAL CONDITIONS IN HEALING CAVITIES IN PULMONARY TUBERCULOSIS.*

By

U. D. GOPAL RAO.

How far natural conditions would render easy the healing up of cavities in Pulmonary Tuberculosis, is a question which should interest us in India, where the disease is playing a great havoc on the masses. The following statistical figures would give us sufficient food for thought and the need to point out the scientific aspect of the problem as regards the possibilities of a cure for the disease by taking a broad survey of the natural resources in India and how these would afford sufficient means to combat the dreadful disease and thus minimise the increasing death rate.

A careful study of the problem has been made in the continental countries and we often read in medical publications the astounding reductions in the mortality rate. This is on account of the organised efforts that have been made to establish health resorts and other hygienic centres where tubercular patients could get beneficial effects. This is evident from some of the following statistical reports :

Statistical Observations about Tuberculosis in India and other Countries.

India.—(*a*) " Public health reports concerning tuberculosis show a decided rise in the death rate from it. Most of the tuberculosis deaths are hidden under the headings " Fevers " and " Respiratory Diseases ". " Bengal Tuberculosis Association seems to suggest that in Bengal alone each year there may be 100,000 deaths from tuberculosis. As a result of these calculations, it has been estimated that of deaths from all causes between 9 and 10 per cent can be taken to be due to tuberculosis."

(*b*) " Out of 6,578,711 people who died in India in 1935 about half a million succumbed to tuberculosis. Tuberculosis is one of the greatest scourges of health and efficiency, both economic and social, and of human life itself.

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* Paper read at the clinical meeting of the South Indian Medical Union on 24-2-1938.

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(c) " Dr. Lankester's comprehensive survey (1914-16) drew attention, however, to the fact that deaths from tuberculosis were increasing in India and there is every reason to believe that this increase has been maintained up to the present time."

(d) " In 1933, General Megaw, on information collected from dispensary doctors all over India, calculated that there were at least 2,000,000 victims of tuberculosis in India."

(e) " It has also been estimated that there are usually 10 cases of tuberculosis in any area for each annual death and on this basis, there are 5,000,000 tuberculosis people in India."

Other Countries.—(a) " India's estimated death rate of about 150 to 200 per 100,000 stands far higher than that of Britain (71 per 100,000) and America (68 per 100,000). Compared with other countries, it is obvious that we are ill-equipped to meet the steadily growing menace of tuberculosis."

(b) " Britain with her infinitely smaller area (50,581 Sq. miles) and population (44,795,357) and death rate, maintains 677 well-equipped and well-staffed tuberculosis clinics. India with an area of 1,808,679 square miles, and a population of 370,000,000 maintains only 40 clinics."

(c) " England maintains 22,355 beds in 191 sanatoria and 16 working colonies, 6,791 beds in general and isolation hospitals together with accommodation for 14,705 children in 146 open-air schools. India, (It is estimated) maintains accommodation for 2,703 patients, out of which 2,255 beds are in sanatoria and special tuberculosis hospitals and most of them are the results of private enterprise, subsidized in a few cases by Local Governments."

Healing process of cavities in Pulmonary Tuberculosis.

(a) *The Ground.*—The Lungs, having an extensive vascular area, offer vast vulnerable ground for tubercular infection which spreading, impairs the resisting power and makes it react more acutely than in any other variety of diseases ; and the presence of a cavity in such an area is always a potential danger to the patient. If it is open, even in spite of good health, it is liable to a number of complications such as hemoptysis, spread of infection in the same or the opposite lung, perforation, persistent sputum containing T. B., rendering the patient a source of danger and infection to his fellow-creatures.

(*b*) *Formation of fibrous tissue ;*

(1) Epitheloid Cells may exhibit prolongation into spindle shaped fibro-blasts which proceed to form connective tissue that gradually penetrates the whole tubercle converting it into fibrous tissue.

(2) Diffuse connective tissue over-growth may render large parts of the lung especially at the apices airless and quite indurated with fibrous infiltration.

(3) The caseous content of the tubercle may remain encapsulated in the connective tissue and be absorbed wholly or partly calcified.

(4) By the formation of the granulation tissue, an empty cavity may become gradually smaller and by cicatrical contractions may naturally heal.

(5) When a cavity is too large and the contraction prevented by adhesions, it may be healed by the formation of a smooth pyogenic membrane.

(*c*) *Accessory treatment to healing process.*

The increase of the natural defensive powers reinforcing vital energy, rendering the tissue soil as invulnerable as possible for growth and spread of the tubercle bacilli, is the *sine qua non* of tuberculosis therapy.

(*d*) *Influence of Climate.*

Increasing the activity of the digestive functions, stimulating nutrition, improving the tone of the nervous and circulatory system, raising the resisting power and thus lessening the liability to the secondary infection are some of the important effects of climate on tuberculosis.

(*e*) *Character of the climate and its therapeutic value.*

Moist and dusty climate whether cold or warm is not suitable for tubercular patients in the second and third stages because the progress of the disease would be hastened.

In high altitudes, air is rarified and the barometric pressure lower than at sea level and the corresponding dimunition of partial pressure of oxygen. This has a physiological effect in rendering the respiration deeper.

Breathing becomes deeper and tissues receive their proper oxygenation. Consequently changes in the blood occur such as increase of red cells and haemoglobin.

The air is much drier at this height and purer and the light and heat of the sun greater than at sea level and there is an absence of wind and dust. This has got a stimulating effect on the respiratory membranes and exert considerable influence on the metabolism and general health of patients. A few months' stay at high altitudes between 4,000 to 5,000 feet above sea level such as in some of the European Alpine resorts, German Mountain resorts, Rockey Mountain resorts and resorts in India would show a change towards the process of healing. Alpine climate has a definite influence on the closure of cavities in tuberculosis of the lungs. Prolonged stay at these heights brings on signs and symptoms of recovery which could be seen by a reduction in the size of the cavity, alteration in the shape, and shrinkage and ultimate closure of cavities in some cases. The reason may be found in the character of the climate and the changes in the human organism that occurs at such altitudes.

(*f*) *Some ways how closure of cavities could be effected.*

1. Natural method—Time, rest and climate treatment.

2. Induction of A. P., when this is possible, combined with the division of adhesions when indicated.

3. Phrenectomy, either alone or in conjunction with the artificial pneumothorax.

4. Plumbage, using wax or De. Winter's operation when the pectoral muscle itself is employed as the plumb

5. Finally operation of thoraco plasty, complete or partial according to necessity.

Natural mothod is the most desirable way of causing obliteration and healing of cavities. This would be understood by knowing the types, the situation, age and state of the wall of cavities.

Stage I. *Stage of pre-cavitation.*—This is characterised radiographically by a circular outline which is soft and not well-marked and the interior not clear. There is absence of expectoration and the necrotic focus has not yet been entirely destroyed or eliminated.

Stage II. Second stage presents a clear circular contour and the interior is filled with muco-purulent expectorations. Walls are composed of pulmonary tissue infiltrated with fresh tubercles and as such not hard, fibrosed and sclerosed.

Stage III. In the third stage, the cavities show a pronounced circular image with a clear centre and with abundant purulent expectoration.

In the apex, healing is not so very easy as in the median region. The cavities are surrounded by pulmonary tissue and cause, on healing, displacement of mediastinum and trachea.

In the median region favourable conditions are placed for rapid healing. Greater amount of pulmonary tissue surrounds the wall which are less liable to be pulled out by adhesions. Cavities which heal rapidly in a few months belong to this type. No trace is seen after healing and a few fibrous shadows are seen in the radiograph.

Medium cavities near hyla are much less easily healed.

Cavities at the bases are in a disadvantageous position because they are constantly and extensively disturbed by the movements of the diaphragm, a condition which is very prejudicial to healing.

From the foregoing, it would be evident that climatic conditions have an important bearing in healing up of cavities in Pulmonary Tuberculosis and cognizance of this important factor should always be borne in mind and necessary investigation should be made in that direction, so that in India which could boast of high altitudes and low levels, suitable health resorts could be established and carefully selected cases from Tuberculosis clinics could be sent there with the full hope of a successful cure.

Active steps should be taken in this direction to combat Tuberculosis which has become a major health problem.

It is earnestly hoped that the scheme launched by Her Excellency, the Marchioness of Linlithgow, to combat tuberculosis in India, would leave no stone unturned to establish on a wide scale natural health resorts for tuberculosis as one of the best ways of prevention of this dangerous disease.

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MEDICINE AND THE MADRAS LEGISLATURE.

The reorganization of the Medical department and particularly the scheme of extension of medical relief by utilizing the honorary services of medical practitioners have come in for a good deal of criticism in the recent discussion on the medical budget in the local legislature. A perusal of the speeches of the members who took part in the discussion gives an impression that the public is nervous about the extension of the honorary scheme. It was suggested that as a result of the honorary scheme efficiency may decline and that corruption may become prevalent. And as the Honorable Minister in charge of the Medical portfolio pointed out in his reply, it is curious that such criticism should be brought forward just as the Government is making strenous efforts to extend the scheme with carefully thought out rules and regulations. Since the inception of the honorary scheme at the end of 1923, there was a continuous demand from the members in the old legislative council for the enlargement of the honorary service. It was as a result of the pressure from the public that two Governments appointed at different times committees to consider the whole question. And both the Committees were unanimous that the scheme was a success and therefore recommended its extension. The Government generally accepted these recommendations, though for some reason or other, during the last four years, not many practitioners were called upon to serve on the hospitals. Even so, there were more than 160 honorary medical officers working in the various hospitals at the time the present Government took office. There are today more than forty such honorary officers

in the City hospitals alone. It is extremely unfair therefore to accuse the present Government of introducing some measure which is untried or of any haste in widening the scope of the already existing scheme.

It is well known that the existing hospitals are overcrowded. The dispensaries and the out-patient departments of the hospitals attract an ever increasing number of patients. In addition to the usual out-patient hours from 7 to 10 in the morning, some of the bigger hospitals have other out-patient clinics which work from 10 a. m. to almost 2 in the afternoon. In spite of these facilities of extended service at the out-patients, the crowding is still large. When it is realised that the increasing number of patients has not been met by any noteworthy increase in the number of medical officers attached to these places, the public and the press like the 'Madras Mail' will not be so ready to attribute other reasons for the delay in the attention to patients at the out-patient clinics.

It is suggested that serious efforts are not made towards diagnosing the ills of people who attend the out-patient departments. The few officers that are available at the out-patient do make an effort to examine the new cases. Even the most hurried examination takes a little time. And those who realise the time required to examine and prescribe for about 100 to 150 patients in a morning will not complain if a few patients are left over beyond the scheduled out-patient working hours. If patients are dissatisfied, they should be such as are not really ill, or those who can certainly afford to be treated by their own doctors outside or those whose employers have not the necessary sympathy to give them sufficient leave to have their illness attended to.

Out-Patient work can certainly be more efficient and expeditious if more doctors could be employed in these places. And people who proclaim the poverty of this country at every step should not object when measures are taken to supply the

necessary medical personnal without incurring greater expense to the State. And it is rather anamolous that those who overflow with sympathy in the press and on the platform for the misery of the poor should be among those who sense disaster when better arrangements are being made to ensure efficiency and speed at the out-patients departments by employing large number of well qualified honorary doctors.

It is freely alleged that the poor and the humble find it increasingly hard to get the necessary attention in the hospitals unless they satisfy the greed of the medical officers. The Madras Mail almost brackets the medical men with ward boys. On account of this allegation they assume that honorary medical officers, because they are not paid by the Government are responsible for this state of affairs. Unfortunately for these critics, there are no honoraries generally in charge of these places, and this allegation has been in existence long before the honorary scheme had been introduced. It is extremely uncharitable therefore to hold the honorary scheme responsible for conditions which are said to have existed before any honorary medical men came on the scene. We hope that the responsible public and the press will hesitate to condemn without evidence a group of men who generously help the public with their willing services in return for the extended facilities for experience which they hope to gather by their association with the hospitals.

NOTICE.

APPEAL TO PRACTITIONERS OF WESTERN SYSTEM OF MEDICINE

Whatever may have been the reasons for your attitude towards practitioners of Indian Medicine in the past, nothing should prevent you from studying Ayurveda systematically hereafter. The Congress Government is pledged to support Indian Arts and Sciences. Ayurveda has been proved beyond doubt by the Osman Committee to be scientific, popular and cheap. Further, Indian Medicine provides ample field for research. You all know that valuable treasures in the form of potent herbs and drugs are being neglected because you were indifferent.

Even in the methods of treatment without the aid of drugs, such as Rasayana or rejuvination, and treatment by Baths, Vyayam and Sweda karmas, which are peculiar to Ayurveda, there is very much to learn. These methods are more suitable to us considering the climatic conditions and habits of our people.

There is no rivalry between yourselves and the Ayurvedic Physicians. Both are anxious to improve each other by incorporating all useful knowledge, whatever be the source from which it is derived. Your co-operation is most necessary in this work. Within 5 years from to-day, there should be no Allopathic doctor, who does not know enough of Ayurveda to make himself understood by the village practitioners. It is just like learning your mother tongue. I hope that with the help and influence of leading doctors and the Universities, a synthetic system will soon be evolved. I earnestly request you to shake off the present attitude of indifference and apathy and do all that you can to bring pressure on the present National Government through the press and medical associations so as to include a course of Ayurveda in the studies at our Medical Colleges in order to give the necessary ' National Back-ground '.

* * *

43, Haries Road,
Mount Road, Madras.
22nd March 1938.

A. LAKSHMIPATHI,
President,
Ayurveda Psachara Sabha.

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION.

Minutes of the meeting of the Council of the Union held on Thursday the 10th March 1938 at 6 p.m. at 32, Broadway, Madras.

The following members were present:—

1. Dr. T. Satakopan.
2. ,, V. C. Sudarsanam.
3. ,, P. Govinda Rao.
4. ,, M. Krishnamurti.
5. ,, G. Zachariah.

Dr. G. Zachariah was in the chair.

The Financial Statements for the months of January and February 1938 were presented and approved.

2. The following practitioners were enrolled as members of the Union :

1. Dr. M. R. Krishnamurthi, L M.P., Tiruvannamalai.
2. ,, N S. Krishnamurti, L.M.P., Trichinopoly.
3. ,, K. P. S. Nambiar, L.M.P., Nilgiris.
4. ,, M. N. Bhat, L.M.P. Hospet, Bellary Dist.
5. ,, R. Narasimhaiah, B.A., M.B.,B.S., Satyamangalam.
6. ,, S. Venkatarama Dheekshathar, Tiruvannamalai.
7. ,, P. S. Ramaswami Iyer, Somwarpet, Coorg.
8. ,, A. Subba Rao, Yellamanchilli.
9. ,, D. Rajamanickam, L.M.P., Conjeevaram.
10. ,, K. Shankaranarayanan, B.A., L M S., Srivilliputtur.
11. ,, N. S. Rajagopala Iyer, L.M. & S., Karur.
12. ,, K. Subbaramiah, L.M P., Kavali.
13. ,, P. Rangaiah Gupta, M B.,B.S., Kavali.
14. ,, G. Sankara Iyer, M.B.,B.S., Koilpatti.
15. ,, T. S. Varadachari, Negapatam.
16. ,, P. S. Nair, L.M.P., Pollachi.
17. ,, K. Subba Razu, Bhimavaram.
18. ,, R. Rajagopalan, L.M.P., Rasipuram.
19. ,, R. N. Ramachandra L.M.P., Udamalpet Post.

20. Dr. G. K. Venkataraman, L.M. & S., Erode.
21. „ P. O. Kuriappan, M.B ,B S., Chittode.
22. „ V. Thangavelu Pillai, Nidamangalam.
23. „ M. R. Subramanyam, L.M.P., Karur.
24. „ K. Srinivasa Pai, L.M.P., Puttur.
25. „ A. S. Hebbar, L.M. & S., Beltangady.
26. „ G. Reddiah, L.M.P., Penumantra.

3. The Secretary was authorised by the Council to transfer Rs. 200/- from the Savings Bank account to the Current account to enable the Union to discharge the current dues to Messrs. Solden & Co., on account of the publicity section.

With a vote of thanks to the chair, the meeting terminated.

UNION NOTES.

A clinical meeting of the South Indian Medical Union was held on 24th February 1938 at 6-15 p.m. at 32, Broadway.

Dr. M. Krishnamurthi took the chair.

Dr U. D. Gopal Rau read an instructive paper on

" The effects of natural conditions in healing cavities in Pulmonary Tuberculosis ".

In the discussion that followed, Dr. V. C. Sudarsanan stressed the importance of Ultra-Violet rays in the treatment. Dr E. V. Sreenivasan drew attention to many favorable resorts within easy reach of Madras which could with benefit be used to a greater extent than was the case at present. Alpine resorts could only be feasible for the very favoured few.

THE INDEPENDENT MEDICAL PRACTITIONERS' ASSOCIATION, TINNEVELLY.

The first Anniversary meeting of the above Association was held on 12th March 1938 under the Presidency of Dr. R. Sundaram, M D. After the the reading of the annual report of the Association by the Secretary, Dr. D. V. Venkappa, Provincial Secretary, The All-India Medical Licentiates' Association, Madras read the memorandum submitted by that Association on the G. O. on the honorary system of Medical Service, published by the Government of Madras a few months back and gave a short resume of the salient defects in the system. Then Dr. R. Sundaram delivered his

LEPROSY

CHAULMOOGRADINE

While Chaulmoogradine tablets may not adequately replace injection treatment of Leprosy, they are nevertheless very useful for reinforcing injection of chaulmoogra preparations, as a maintenance treatment between courses of injections and as a precautionary treatment against relapse following the cessation of injections.

Relapse often occurs through treatment being stopped too soon. Sometimes a complicating disease may suppress the cellular reaction to the B. Leprae, as a result of which the disease may appear to be arrested, but actually is only quiescent.

The administration of Chaulmoogradine tablets at the cessation of injection treatment will serve to maintain resistance to the B. Leprae, and reduce the danger of relapse.

The tablets are composed of salts of the total unsaturated fatty acids present in chaulmoogra oil; they are convenient to take and remarkably free from any deleterious action on the stomach.

COMPOSITION: Gluten coated tablets each containing ½ gram of the sodium salts of Chaulmoogric and Hydnocarpic acids.

ADVANTAGE: The gluten coating prevents gastric disturbances.

DOSE: One tablet three times a day, which may be increased to six tablets per day in some cases.

PACKING: Bottles of 100 tablets.

PHARMASOL CHAULMOOGRA

COMPOSITION: A colloidal preparation of Chaulmoogra oil.

Strengths	Ampoules	Vials.
0·1 per cent.	2 cc and 5 cc	25 cc
0·2 ,, ,,	2 cc	25 cc
0·5 ,, ,,	2 cc	25 cc
1·0 ,, ,,		25 cc
2·5 ,, ,,		25 cc

DOSAGE: Begin with ½ to 2 cc of 0·1 per cent every 2nd day. Gradually increase the dose and interval till 5 cc or more of 1·0 per cent or 2·5 per cent is given once a week.

METHODS: Intramuscular or intravenous as convenient.

ADVANTAGES: No venous occlusions.

The Anglo-French Drug Co. (Estn.) Ltd.,

P. O. Box 460 — BOMBAY.

THE MEDICAL ORGANISATION YOU NEED AND TO WHICH YOU SHOULD BELONG.

THE GENERAL SECRETARY,

South Indian Medical Union, Madras.

Dear Sir,

I desire to become a member of the South Indian Medical Union, and request you to place this application before the Governing Body.

I am, yours truly,

Name..

Membership Fee :

Madras Rs. 10 per annum. *Address*..

Mofussil Rs. 3 ,,

....

Please detach and post.

JOURNAL OF SOUTH INDIAN MEDICINE

NOTICE

CONTRIBUTIONS of medical interest—original articles, case notes, clinical memoranda—are invited. They should be addressed to the EDITOR, JOURNAL OF SOUTH INDIAN MEDICINE, NO. 7, RITHERDON ROAD, VEPERY, MADRAS, and should be accompanied by a stamped addressed envelope if their return is desired in case of non-publication.

Articles are accepted for publication on condition that they are contributed solely to this JOURNAL.

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MANUSCRIPTS must be written clearly or preferably type-written, with double spacing, on one side of the paper only.

Books and pamphlets for review should be sent to the Editor, who will be pleased to receive also reprints of which abstracts will be of interest to the profession. Journals for exchange or review should be addressed to the Publicity Officer.

address on "our profession some thoughts." He traced the progress and development in medicine and surgery during the past 50 years. He dealt with the advances made in anaesthesia, in tropical medicine, in Bacteriology and Bio-Chemistry, Endocrinology and Hormone therapy, Radiology and Radium Therapy, Neurology and Psychiatry and in Therapeutics. Regarding the future of the profession, he said more attention should be paid to the preventive side rather than to the curative and spoke a few words regarding the correct code of conduct for medical men and wound up his lecture by saying that medicine, though a noble profession is a sorry trade and if the making of money is the chief aim of man, this is not the profession for him. After the usual vote of thanks, the meeting terminated.

THE FIRST ANNUAL REPORT 1937—'38.

The idea of having an Association of the independent medical practitioners with a view to cultivate and foster *espirit de corps* among them, to subscribe for medical journals and circulate them, and to meet and discuss topics of medical interest was in the air for a long time and it took a final shape at a preliminary meeting of the independent medical practitioners of Tinnevelly and Palamcottah which was held at Dr. L. Mahadevan's Eye clinic, Vannarpet, on 19th March 1937, when 21 independent medical practitioners of Tinnevelly and Palamcottah were present. Dr. R. Sundaram, M.D., presided over this meeting and the rules of the Association were framed.

The following office-bearers were elected for the year:

(1) Dr. R. Sundaram, M.D., President.
(2) ,, T. N. Govinda Aiyer, M.B. C.M., Vice-President.
(3) ,, A. R. Visvanathan, L.M. & S., Secretary and Treasurer.
(4) ,, V. Narayanachari, L.M.P. } Members of the Managing Committee.
(5) ,, T. S. Vaikuntaraman, L.M.P. } Members of the Managing Committee.
(6) ,, K. R. Venkoba Rao, L.M. & S., B.S.SC., Auditor.

There were 24 members in the beginning; of these 19 subscribed for journals. 4 members joined the Association during the year, of whom, one is from Tenkasi and the other from Koilpatti. It is our earnest desire that every independent medical practitioner of the district should join the Association and thus strengthen the same, since this is the only one of its kind. The rules of the Association have been so framed that even those who are in service can join the same as associate members and derive the benefits of the Association.

The inaugural meeting of the association was held on 10th April 1937, and an inaugural address on the " Art of Private Practice " was delivered by Dr. T. N. Govinda Aiyer. For this meeting invitations were issued to all the independent medical practitioners in the district.

The Association has been subscribing for " The Lancet " and " The Practitioner " from April 1937, and the " Medical Press and Circular " from October 1937, and " The Journal of American Medical Association " from January 1938. Of these, three are weekly and one monthly.

The Association has been holding from the very beginning a clinical meeting on the 2nd Saturday of every month at Dr. L. Mahadevan's Eye clinic, Vannarpet, except one at Dr. G. N. Kantayya's X-ray clinic, Palamcottah. At every meeting one member delivered a lecture on some clinical subject followed by discussion by members.

The average attendance at these meetings was 16.

There was an extraordinary meeting on 28th July 1937, when Mr. R. Venkateswaran of the Havero Trading Company exhibited certain medical films. For this meeting invitations were issued to the members of the Tinnevelly District Medical Association residing within the municipal limits of Tinnevelly and Palamcottah. This was responded to by Lieut. Col. T. S. Shastry, I. M. S., its president and 5 other members

The Association was invited for the Ninth Annual Re-union of the Tinnevelly District Medical Association and it responded to the same.

The Association congratulated Dr. U. Rama Rau, Dr. T. S. S. Rajan, and Dr. A. Lakshmanasamy Mudaliar, on their becoming the President of the Legislative Council, Madras, Public Health Minister to the Government of Madras, and Principal, Medical College, Madras, respectively.

The Association was represented by two members. Drs. T. N. Govinda Ayyar and K. Rama Ayyar, at the XIV All India Medical Conference at Madras last December.

The Association places on record its gratefulness and sincere and heartfelt thanks to Dr. L Mahadevan for his unreservedly placing his clinic at the disposal of the Association for holding its monthly meetings, etc.

The Managing Committee met 7 times in the year and transacted all the business placed before it.

ACCOUNTS.

The accounts of the Association have been duly audited and are as follows :—

Income	Rs.	A.	P.	*Expenditure*	Rs.	A.	P.
General Subscription	106	0	0	Subscriptions for Journals	109	15	0
Journal Subscription	123	0	0	Stationery	2	6	0
By interest	0	9	1	Postage	3	2	0
				Printing charges	9	15	0
				Establishment	33	0	0
				Cash on hand	0	10	0
				Cash in Quilon Bank	70	9	1
Total	229	9	1	Total	229	9	1

THE LIST OF MEMBERS OF THE ASSOCIATION DURING 1937—38.

1.	Dr. R. Sundaram, M.D.	Palamcottah.
2.	,, G. N. Kantayya, B.A., M.B.B.S.	,,
3.	,, V. Sankarasubban, M.B.B.S.	,,
4.	,, N. Isaac, L.M.P.	,,
5.	,, J. Jesudoss Pillai, L.M.P.	,,
6.	,, A. Arulanandam, L.M.P.	,,
7.	,, V. Narayanachari, L.M.P.	,,
8.	,, S. N. Sreenivasa Pillai, L.M.P.	,,
9.	,, A. G. Michael, L.M.P.	,,
10.	,, L. Mahadevan, M.B.B.S., D.O.M.S., (Lond,),	Vannarpet.
11.	,, K. S. Aiyengar, L.M. & S.	,,
12.	,, K. Subramanya Pillai, L.M.P.	,,
13.	Mrs. E. Bernard Carr	,,
14.	Dr. P. R. Subbier, L.M. & S.	Veeraraghavapuram.
15.	,, A. R. Visvanathan, L.M. & S.	,,
16.	,, K. R. Venkoba Rao, L.M. & S., B.S.Sc.	
17.	,, K. Venkatasubramanyam, L.M. & S.	,,
18.	,, R. V. Padmanabhan, M.B.B.S.	,,
19.	,, R. V. Chockalingam, B.A., M.B B.S.	Tinnevelly Town.
20.	,, T. N. Govinda Aiyer, M.B.C.M.	,,

21.	Dr. R. S. Harihara Aiyer, M.B.C.M.	Tinnevelly Town.
22.	„ K. Rama Ayyar, M.B.B.S. (Andhra)	„
23.	„ S. K. Ganapathi Aiyer, L.M. & S.	„
24.	„ P. Suryanarayana Aiyer, L.M.P.	„
25.	„ K. R. Muthukumaraswamy, L.M.P.	„
26.	„ T. S. Vaikuntaraman, L.M.P.	„
27.	„ S. N. Rangachari, L.M.P.	Tenkasi
28.	„ G. Dorairaj, M.B.B.S.	Koilpatti

TINNEVELLY, 12—3—38.

A. R. VISVANATHAN, L.M. & S.
Secretary and Treasurer.

ANDHRA MEDICAL CONFERENCE.

The West Godavary District Medical Association Managing Committee met on 27th February 1938 in Tadepalligudem Higher Elementary School at 3 p.m. and passed some resolutions important among which are :—

1. The date of the anniversary of the association is fixed to be 30th April 1938 and the Surgeon-General be requested to preside on the occasion.

2. That the Andhra Medical Conference be held at Ellore on 1st May 1938.

3. That the West Godavary District Medical Association be the Reception Committee.

4. That election of President is to be invited from among (*i*) Dr. T. S. S. Rajan, F.R.C.S., Minister of Health, Madras ; (*ii*) Dr. A. Lakshmanaswami Mudaliar, M.D., Superintendent, Maternity Hospital, Madras, and (*iii*) Dr. Muller, M.D., Superintendent, Tuberculosis Sanatorium, Madanapalle, being the panel of Presidents elected by the Committee.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(*Tinnevelly Branch of the Indian Medical Association*).

MONTHLY MEETING.

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 26th of February 1938, at 4-30 p.m. at the Nanguneri Hospital. After light refreshments and sweet music, the meeting began under the Presidentship of Lieut. Col. T. S. Shastry, I.M.S. Members

numbering 36 were present on the occasion. M.R.Ry. J. L. P. Roche Victoria, Avl , M.L.A., was also present on the occasion.

Dr. K. Rama Ayyar, M.B.B.S , (Andhra)., the Secretary and Treasurer, read the minutes of the Anniversary Meeting of the Association held on Saturday the 22nd of January 1938, which were passed.

Lieut. Col. T. S. Shastry, I.M.S., appealed to all those present to subscribe liberally towards the Centenary Fund of the London Mission Hospital, Neyyoor.

Dr. M. Vaithianathan, L M.P., Sub-Assistant Surgeon, Government Hospital, Nanguneri, presented to the members a case—a growth on the back of the tongue.

Dr T. K. Nilakanta Iyer, L.M.P., Selection Grade Sub-Assistant Surgeon, Government Headquarters Hospital, Palamcottah, read out the following interesting cases which were treated at the Headquarters Hospital, Palamcottah :—

1. A case of Neuralgia - cured with I. V. Injections of $MgSO_4$.
2. A case of Pneumonia with Thrombosis of right upper limb.
3. A case of Cystitis—due to conginental syphilis—a child of four years.

Dr. K. Padmanabha Iyer of Tenkasi, read out an interesting paper on " Food-Drunkenness ".

Thereafter Dr. K. Rama Ayyar, M.B.B.S., (Andhra)., read short notes on the treatment of Burns which is a precis of Mr. Mitchiner's article in the B M.J.

After detailed discussion by the members, Lieut. Col. T. S. Shastry, I. M. S., summed up the salient and important features of all the cases. He offered his cordial thanks to those who helped towards the success of the function and thanked Dr. M. Vaithianathan for the excellent arrangements. Thereafter an excellent Dinner brought the happy gathering to a close.

In the morning a Health Exhibition was arranged at Nanguneri. About 300 School Teachers and School Mistresses of Nanguneri Taluk attended the Health Exhibition which was held at the same place along with the Annual Conference of the Elementary School Teachers' Association. The Exhibits consisted of posters relating to Cholera, Tuberculosis, Malaria, Small-pox, Fly-danger, etc. The Exhibition was kept open till late in the evening.

The Dr. B. S. Shroff Memorial Gold Medal

OF THE

BOMBAY MEDICAL UNION.

The following subject has been selected by the Bombay Medical Union for competitive thesis for the above Prize for 1938 :—

" Tuberculosis in general, paying special attention to its prevention and treatment."

The award will be in the form of a Gold Medal called the DR. B. S. SHROFF MEMORIAL GOLD MEDAL of the BOMBAY MEDICAL UNION.

The competitor must be (i) a duly qualified member of the Medical Profession holding a degree or degrees and diplomas from Indian and other Universities created by statute, or (ii) a duly qualified member of the Medical Profession holding the diploma of Membership of College of Physicians and Surgeons of Bombay.

The thesis must be sent in six typed copies so as to reach the Honorary Secretaries, Bombay Medical Union, Blavatsky Lodge Building, French Bridge, Chowpatty, Bombay, on or before the 15th August 1938.

The thesis should be designated by a motto instead of the writer's name and should be accompanied by a sealed cover containing the name of the writer and his Post-Office Address.

The name of the Prize, the year of competition, the subject of the thesis and the writer's motto should be superscribed on the cover.

No study or essay that has been published in the medical press or elsewhere will be considered eligible for the Prize, and no contribution offered in one year will be accepted in any subsequent year unless it includes evidence of further work.

The accepted thesis shall be the property of the Bombay Medical Union.

All other thesis shall be returned if not accepted provided the return postage expenses are paid in advance by the writer.

In the award of the Prize to the successful candidate, the decision of the Committee shall be final.

SORAB J. POPAT, M B., B.S.,
M. B. THAKORE, M.B., F.R C.S.,
Hon. Secretaries,
BOMBAY MEDICAL UNION.

Bombay, 15th February 1938.